Application Checklist for Speech-Language Pathology

Licensed in Another State

(US Graduates)

1. **Application**

2. **License Fees**
   - Check or Money Order to Board for $60.

3. **Letters of Good Standing**
   - Originals and from each state where you were licensed.

4. **Fingerprints**
   - If a California resident, must do Livescan; send a copy of your form to the Board. Fees paid directly to Livescan Operator.

   - If out-of-state, send four cards and a check or money order to Board for $49 to cover DOJ and FBI.

5. **Transcripts**
   - Sent directly from the universities.

6. **Copy of Diplomas**

7. **Clinical Practicum**
   - Must be on our form

8. **National Exam Score**
   - Must have minimum passing score of 600.
   - Must be within five years.
   - Must be sent from NTE to our Board.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 WWW.SPEECHANDHEARING.CA.GOV

APPLICATION FOR LICENSURE

FOR OUT-OF-STATE APPLICANTS

OFFICE USE ONLY	
RECEIPT #:	
ATS #:	
AMOUNT PAID:	
DATE CASHIERED:	

IMPORTANT: IF YOU HAVE PENDING OR CURRENT ASHA CERTIFICATION THIS IS THE WRONG APPLICATION. YOU SHOULD USE THE CERTIFICATE OF CLINICAL COMPETENCE APPLICATION PACKAGE.
INSTRUCTIONS: ANY CORRECTIONS TO THIS FORM MUST BE STRICKEN AND INITIALED. **DO NOT USE WHITE OUT OR CORRECTION TAPE ON THIS APPLICATION!** IF ANY SECTIONS ARE NOT COMPLETE, THIS APPLICATION WILL BE RETURNED. YOU MUST INCLUDE A CHECK OR MONEY ORDER FOR $60.00 ALONG WITH THIS APPLICATION.

NOTICE: EFFECTIVE JULY 1, 2012, THE STATE BOARD OF EQUALIZATION AND THE FRANCHISE TAX BOARD MAY SHARE TAXPAYER INFORMATION WITH THE BOARD. YOU ARE OBLIGATED TO PAY YOUR STATE TAX OBLIGATION AND YOUR LICENSE MAY BE SUSPENDED IF THE STATE TAX OBLIGATION IS NOT PAID.

SPEECH-LANGUAGE PATHOLOGY ☐ **AUDIOLOGY** ☐ **DISPENSING AUDIOLOGIST** ☐

PLEASE TYPE OR PRINT NEATLY

1. FULL NAME: LAST FIRST MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):
3. *ADDRESS: STREET
   CITY, STATE, ZIP CODE
4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:
5. SOCIAL SECURITY NUMBER: DATE OF BIRTH: (MM/DD/YYYY)
   EMAIL ADDRESS:
6. EDUCATION:
   MASTER'S DEGREE ☐ MASTER'S DEGREE EQUIVLENCY ☐ AU.D. DEGREE OR AU.D. STUDENT ☐
7. EMPLOYER:
   STREET ADDRESS: CITY, STATE, ZIP CODE:

8. GRADUATE AND UNDERGRADUATE PROGRAMS. YOU MUST PROVIDE GRADUATE AND UNDERGRADUATE TRANSCRIPTS.

INSTITUTION NAME	CITY/STATE	MAJOR FIELD OF STUDY	DEGREE RECEIVED AND DATE

*YOUR ADDRESS IS PUBLIC INFORMATION AND WILL BE PLACED ON THE INTERNET.

9. HAVE YOU TAKEN THE EDUCATIONAL TESTING SERVICE/NATIONAL TEACHER EXAMINATION (NTE) (THE PRAXIS SERIES) IN SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY?

YES _____ NO _____ IF YES, DATE _____/_____ (MONTH / YEAR) YOUR SCORE:_____ (MINIMUM SCORE OF 600 REQUIRED)

NOTE: YOU MUST HAVE THE EDUCATIONAL TESTING SERVICE (PRAXIS SERIES) SEND STANDARD SCORE EXAMINATION RESULTS DIRECTLY TO OUR OFFICE.

10. IN WHAT STATE WAS YOUR SUPERVISED PROFESSIONAL EXPERIENCE, CFY, OR 4TH YEAR EXTERNSHIP COMPLETED?

_____

IF IT WAS COMPLETED IN CALIFORNIA YOU WILL BE REQUIRED TO SUBMIT A REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM.

11. HAVE YOU EVER BEEN LICENSED TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, OR HEARING AID DISPENSING IN ANY STATE OR COUNTRY?

YES _____ NO _____ IF YES, WHAT STATE(S) OR COUNTRY _____

12. DO YOU HAVE ANY PENDING OR HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN OR CHARGES FILED AGAINST A SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE? INCLUDE ANY DISCIPLINARY ACTIONS TAKEN BY ANY STATE OR OTHER U.S. FEDERAL GOVERNMENT ENTITY.

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

DISCIPLINARY ACTION INCLUDES, BUT IS NOT LIMITED TO, SUSPENSION, REVOCATION, PROBATION, CONFIDENTIAL DISCIPLINE, CONSENT ORDER, LETTER OF REPRIMAND OR WARNING, OR ANY OTHER RESTRICTIONS OF ACTION TAKEN AGAINST A SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE.

13. ARE THERE ANY PENDING INVESTIGATIONS BY ANY STATE OR FEDERAL AGENCIES AGAINST YOU?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

14. HAVE YOU EVER BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION REGARDING ANY SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE, WHICH YOU NOW HOLD OR HAVE PREVIOUSLY HELD?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

15. HAVE YOU EVER BEEN DENIED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS, IN ANY STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

16. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS IN ANOTHER STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

17. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY OF ANY STATE, THE UNITED STATES OR A FOREIGN COUNTRY? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF $300 OR LESS)

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND/OR DISMISSED UNDER PENAL CODE SECTION 1203.4 OR UNDER ANY OTHER PROVISION OF THE LAW.

18. AUDIOLOGY APPLICANTS ONLY, DO YOU WISH TO DISPENSE HEARING AIDS?

YES _____ NO _____ IF YES, COMPLETE THE HEARING AID DISPENSER WRITTEN LICENSE EXAMINATION APPLICATION

YOU MUST REPORT TO THE BOARD THE RESULT OF ANY ACTIONS WHICH HAVE BEEN FILED OR WERE PENDING AGAINST ANY SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE YOU HOLD AT THE FILING OF THIS APPLICATION. FAILURE TO REPORT THIS INFORMATION MAY RESULT IN THE DENIAL OF YOUR APPLICATION OR SUBJECT YOUR LICENSE TO DISCIPLINE PURSUANT TO SECTION 480 (C) OF THE BUSINESS AND PROFESSIONS CODE.

ATTACH 2" X 2" OR 3" X 3"
PASSPORT QUALITY
PHOTOGRAPH HERE. YOU MUST PRINT YOUR FULL NAME ON THE BACK OF THE PHOTOGRAPH. THE PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE 60 DAYS OF THE FILING DATE OF THIS APPLICATION.

PHOTOS PRINTED ON WHITE BOND PAPER ARE **NOT** ACCEPTABLE.

I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR SUSPENSION OR REVOCATION OF A LICENSE.

DATE: _____ SIGNATURE: _____
(SIGNATURE MUST BE IN BLUE INK)

REPORT OF CLINICAL PRACTICUM

SPEECH-LANGUAGE PATHOLOGIST

ATTENTION APPLICANT: Complete **both pages** of this form and send to the college or university for verification by current training program director. Any corrections to this form must be stricken and initialed. **DO NOT USE WHITE OUT OR CORRECTION TAPE ON THIS FORM**.

Supervised Clinical Practicum - The applicant must submit evidence of completion, in conjunction with academic course requirements, in accordance with Section 1399.152.2 of Article 3 of Division 13.4 of Title 16 of the California Code of Regulations.

The requirements are two hundred seventy-five (275) clock hours of clinical experience shall be required for licensure as a speech-language pathologist or audiologist for applicants who completed their graduate program on or before December 31, 1992; and three hundred (300) clock hours of clinical experience in three (3) different clinical settings shall be required for licensure as a speech-language pathologist or audiologist for applicants who completed their graduate program after December 31, 1992.

Twenty-five (25) hours of the required clinical experience may be in the field other than that for which the applicant is seeking licensure (speech-language pathology for an audiologist or audiology for a speech-language pathologist) if such clinical experience is under a supervisor who is qualified in the minor field as proved in subsection (a). Authority cited: Section 2531.95, Business and Professions Code. Reference: Section 2532.2, Business and Profession Code.

Clock hours obtained in a California college or university January 1980 or thereafter must be under the supervision of a licensed speech-language pathologist.

PRINT Applicant's full name _____

Social Security Number_____

University or College _____

ATTENTION TRAINING PROGRAM DIRECTOR: This is a two (2) page document. Please sign the lower left hand corner of the first page and the upper left hand corner of the second page in blue ink. Mail the signed form directly to the following address:

Speech-Language Pathology and Audiology Board
2005 Evergreen Street, Suite 2100
Sacramento, CA 95815

I certify that all practicum information listed on the back of this form was completed according to all ASHA and State of California practicum requirements.

_____	_____	_____
Signature of Current Training Program Director (Blue Ink)	Date	License Number or ASHA Certification Number

(Rev Jul-09)

CLINICAL PRACTICUM

(Speech-Language Pathology)

_____ Signature of Training Program Director (BLUE INK)

_____ PRINT Applicant's full name

EVALUATION: ADULTS

Supervisor's Full Name	Location Where Experience was Obtained	Supervisor's CCC Area (SP/AU)	Date of Experience Mo/Yr – Mo/Yr	Record hours under areas in which they were obtained					
				Articulation Disorders	Language Disorders	Voice Disorders	Fluency Disorders	Related Disorders	Dysphagia

TOTALS:

EVALUATION: CHILDREN

TOTALS:

TREATMENT: ADULTS

TOTALS:

TREATMENT: CHILDREN

TOTALS:

AUDIOLOGY (for majors in speech-language pathology)

Supervisor's Full Name	Location Where Experience was Obtained	Supervisor's CCC Area (SP/AU)	Date of Experience Mo/Yr – Mo/Yr	Record hours under areas in which they were obtained			
				Evaluation/Screening		Treatment	
				Screening	Audiologic Evaluation	Amplification (Hearing Aid Selection, Treatment)	Treatment of Communication Handicaps of the Hearing Impaired

TOTALS:

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REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM

INSTRUCTIONS AND IMPORTANT INFORMATION: This form must be completed and submitted within 10 business days of termination of supervision, change in time base or at the end of your experience. Full-time and part-time experience can not be combined on the same form. If you are working in a public school you will be required to submit a separate verification form for each school year. You must also provide a calendar for each school year. If you work during the summer you will be required to submit a separate verification form for the summer session. You will also be required to provide a letter from the school district that defines the dates and hours of the summer school session. Any corrections to this form must be stricken and initialed by the supervisor. Do **NOT** use white out or correction tape on this form. Do **not** fax this form to the Board.

THIS SECTION MUST BE COMPLETED BY THE APPLICANT. PLEASE TYPE OR PRINT LEGIBLY.

1. APPLICANT'S NAME: LAST FIRST MIDDLE

2. APPLICANT'S ADDRESS OF RECORD: WOULD YOU LIKE YOUR ADDRESS CHANGED? _____ YES _____ NO

_____
SIGNATURE AUTHORIZING ADDRESS CHANGE

CITY, STATE, ZIP CODE: PHONE NUMBER: ( )

3. SOCIAL SECURITY NUMBER: - - RPE NUMBER: DATE OF BIRTH: (MM/DD/YY) / /

EMAIL ADDRESS: (OPTIONAL)

THIS SECTION MUST BE COMPLETED BY THE SUPERVISOR. PLEASE TYPE OR PRINT LEGIBLY.

4. SUPERVISOR'S NAME: LAST FIRST LICENSE NUMBER:

5. SUPERVISOR'S ADDRESS:

CITY, STATE, ZIP CODE:

6. NAME AND ADDRESS WHERE EXPERIENCE WAS ACTUALLY OBTAINED: (DO NOT PROVIDE AGENCY INFORMATION)

7. STREET ADDRESS:

8. CITY, STATE, ZIP CODE: PHONE NUMBER: ( )

9. NUMBER OF HOURS APPLICANT WORKED PER WEEK:

10. DATES OF EXPERIENCE: (MM/DD/YY)
(MUST REFLECT ONLY THE DATES **YOU** PROVIDED SUPERVISION)
FROM: / / TO: / /

*DOCTORATE OF AUDIOLOGY STUDENTS **ONLY**. THIS APPLICANT HAS COMPLETED THE 4TH YEAR (12-MONTH EXTERNSHIP) AS REQUIRED BY THE AUDIOLOGY DOCTORAL PROGRAM:
YES ____ NO ____

PRINT APPLICANTS FULL NAME _____ RPE NUMBER _____

11. WAS THE APPLICANT EMPLOYED AS A SALARIED EMPLOYEE OF A PUBLIC SCHOOL (COUNTY OFFICE OF EDUCATION)?

YES ____ NO ____

A. WHAT WAS THE SCHOOL SCHEDULE: TRADITIONAL _____ YEAR ROUND _____ SUMMER SCHOOL _____

YOU MUST ATTACH A SCHOOL CALENDAR THAT REFLECTS THE NAME OF SCHOOL OR DISTRICT AND ALL SCHOOL BREAKS AND HOLIDAYS.

WILL THE APPLICANT CONTINUE TO WORK UNDER YOUR SUPERVISION IN THE FALL?

YES ____ NO ____

12. SUPERVISION:

____ I PROVIDED EIGHT HOURS A MONTH OF DIRECT SUPERVISION. FOUR OF THE EIGHT HOURS WERE IN SCREENING, THERAPY, AND EVALUATION.

____ I PROVIDED FOUR HOURS A MONTH OF DIRECT SUPERVISION. TWO OF THE FOUR HOURS WERE IN SCREEN, THERAPY, AND EVALUATION.

13. PERFORMANCE OF RPE APPLICANT WAS:

SATISFACTORY ☐ UNSATISFACTORY ☐

COMMENTS:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I HAVE DISCUSSED THE FOREGOING WITH THE APPLICANT AND THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT, AND I DID NOT SUPERVISE MORE THAN TWO (2) OTHER APPLICANTS OBTAINING THEIR REQUIRED PROFESSIONAL EXPERIENCE (RPE) DURING THE SAME PERIOD OF TIME. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS VERIFICATION, OR FOR SUSPENSION OR REVOCATION OF MY LICENSE.

_____ DATE

_____ SUPERVISOR'S SIGNATURE (IN BLUE INK)

INFORMATION COLLECTION AND ACCESS

THE SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD'S EXECUTIVE OFFICER IS THE PERSON WHO IS RESPONSIBLE FOR INFORMATION MAINTENANCE. SECTION 2532 OF THE BUSINESS AND PROFESSIONS CODE IS THE AUTHORITY, WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION. ALL INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY MANDATORY INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE. THE INFORMATION PROVIDED WILL BE USED TO DETERMINE QUALIFICATION FOR LICENSURE. EACH INDIVIDUAL HAS THE RIGHT TO REVIEW HIS OR HER FILE MAINTAINED BY THE AGENCY SUBJECT TO THE PROVISIONS OF THE CALIFORNIA PUBLIC RECORDS ACT.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

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Agency Address Set Contributing Agency:

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Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

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City State Zip Code

( )
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Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

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Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

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( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

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OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

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THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**